DISTRICT OF COLUMBIA
DOH Office of Adjudication and Hearings

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH Petitioner, v. KEISHA HOLMES Respondent	Case No.: C-00-80017

FINAL ORDER

I. Introduction

Respondent Keisha Holmes is a nurse aide who has worked at two nursing homes in the District of Columbia. On August 10, 2000, the Government served her with a notice of its intent to list her in the Abuse Section of the Nurse Aide Registry, which is maintained pursuant to 29 DCMR 3251 and 3252.[1] Pursuant to 29 DCMR 3252.6 and 3253.1, the notice informed Ms. Holmes of her right to challenge the proposed listing by requesting a hearing before this administrative court within 20 calendar days of her receipt of the notice.[2]

[1] Federal Medicaid regulations require a participating State to maintain a nurse aide registry that includes information on any findings of abuse, neglect or misappropriation of funds by a nurse aide. 42 C.F.R. 483.156.

[2] The regulations originally granted authority over the Nurse Aide Registry to the Department of Consumer and Regulatory Affairs. That authority has been transferred to the Department of Health, and this administrative court has jurisdiction to decide this case pursuant to Reorganization Plan No. 4 of 1996, Mayor's Order No. 97-42, Mayor's Order No. 99-68 and Department of Health Organizational Order No. 99-24.

Ms. Holmes filed a timely hearing request on August 21, 2000, and an evidentiary hearing was held on August 30, 2000.[3] Mary Sklencar, an investigator employed by the Department of Health, testified about her investigation of two incidents involving Ms. Holmes, including her interviews of witnesses and her review of documents. The Government also introduced several documents (Petitioner's Exhibits 100-120), which I admitted into evidence. Ms. Holmes appeared on her own behalf and testified. She did not offer any documentary evidence at the hearing. As described in greater detail below, the record did not close until September 15, 2000 to allow Ms. Holmes an opportunity to present additional evidence.

Based upon the testimony in the record, my evaluation of the credibility of the witnesses and the documents admitted into evidence, I now make the following findings of fact and conclusions of law. Pursuant to 29 DCMR 3253.5, this decision is being filed within thirty days of the close of the record.

II. Findings of Fact

A. The January 10 Incident

On January 10, 2000, Ms. Holmes was employed as a nurse aide at Carroll Manor Nursing and Rehabilitation Center. She had worked at the facility for about two years, first as a part-time employee and then as a full-time employee. On the morning of January 10, she

[3] Section 3253.2 of 29 DCMR requires a hearing to be held within ten days of the receipt of a hearing request.

brought one of the residents (Resident A) to a bathroom in order to give her a bath.[4] The resident was severely visually impaired, and suffered from Alzheimer's Disease, psychosis, vascular disease and other ailments. She was independent in bed mobility, but totally dependent in all other activities, including dressing, eating, toilet use, personal hygiene and bathing. Petitioner's Ex. 100 at 2.

Ms. Holmes regularly cared for Resident A. Her usual practice when bathing Resident A was to take her to a bathroom directly across the hall from her room. Ms. Holmes would run the water, help the resident into the bathtub, and return to the resident's room across the hall to get items that she needed such as clean clothing for the resident.

The bathtub is depicted in Petitioner's Ex. 120. It is between 4 and 4 ½ feet tall and is specially designed both to allow entry through the side and to permit the user to be bathed in a sitting or reclining position. If the tub is reclined, the water will come up to the bather's shoulders. The facility had distributed detailed instructions for the tub's use to the nurse aides, including Ms. Holmes. Those instructions stated that a resident never should be left alone in the tub. Petitioner's Ex. 120 (Step 4). Ms. Holmes acknowledged that her practice of leaving the bathroom to go across the hall violated those instructions.

On January 10, the bathroom across the hall from Resident A's room was out of service. Consequently, Ms. Holmes took her to a bathroom in a different wing of the facility. She helped the resident into the tub, put the tub into a reclining position, and turned on the water. She then

[4] Pursuant to 29 DCMR 3252.13, I will not identify the resident.

left the bathroom to return to the resident's room to get clean clothes. As she was returning, another resident stopped her and asked Ms. Holmes for help with her hair. Ms. Holmes was not assigned to care for that resident, but she often helped her with her hair because the resident complained that her assigned aide did not do a good job. At first, Ms. Holmes declined the request. The resident was insistent, however, and Ms. Holmes agreed. She fixed the resident's hair and then resumed her journey back towards the bathroom. Ms. Holmes was absent from the bathroom area for at least seven minutes, and possibly more.

Shortly before Ms. Holmes' return to the bathroom area, another employee of the facility noticed water running underneath the bathroom door and out into the hallway. That employee opened the door and found that the water had overflowed the tub and that the resident was lying on her side in the tub with her face in the water. She called for assistance, and several staff members responded. They performed CPR, and called for an ambulance. While they were performing CPR, the resident vomited a blue liquid. Paramedics arrived and took her to the hospital, where she was pronounced dead shortly after her arrival.

Ms. Sklencar testified that the medical examiner's office had determined that the cause of the resident's death was drowning. On the hearing date, however, an autopsy report had not yet been prepared, even though the resident had died more than seven months earlier. Ms. Sklencar obtained her information about the cause of death in conversations with the medical examiner who performed the autopsy.

Ms. Holmes vigorously disputed the contention that Resident A had drowned. She testified that, even with the tub in a reclining position, the resident's head would have been above the water. Ms. Holmes also expressed the opinion that Resident A, notwithstanding her physical limitations, had sufficient strength and presence of mind to lift her head if she slipped under the water. Although the medical examiner had told Ms. Sklencar that the blue liquid that Resident A had vomited was soap, Ms. Holmes testified that the facility did not use blue soap, but that Resident A usually took a blue-colored medication. In Ms. Holmes' view, Resident A's vomiting of blue liquid did not prove that she had swallowed water from the tub or that water was in her lungs. Ms. Holmes speculated that there was some cause for Resident A's death other than drowning.

Ms. Holmes had no opportunity to learn of the medical examiner's conclusions before the hearing. Because the medical examiner did not testify, Ms. Holmes had no opportunity to cross-examine the medical examiner and to bring to her attention the facts that she believed would refute a conclusion that Resident A drowned. Consequently, I left the record open until September 15, 2000 in order to permit Ms. Holmes an opportunity to speak with the medical examiner and to include in the record information derived from any such conversation. Ms. Holmes has not filed any new information nor did she seek to supplement the record on this issue.

Despite the absence of any information from Ms. Holmes, I will not make any findings about the cause of Resident A's death. As explained below, such a finding is not necessary to

resolve this case. The issue is whether Ms. Holmes neglected Resident A, not whether she caused Resident A's death.[5]

B. The August 18 Incident

At the hearing, the Government moved to amend its notice letter of August 10, 2000 to include a claim that Ms. Holmes had abused a resident of a different nursing home on August 18, 2000, eight days after the original notice letter was sent to Ms. Holmes. Ms. Holmes expressly stated on the record that she did not object to consideration of the August 18 incident at the hearing, and she recognized that it could be an independent basis for listing her in the Abuse Section of the Nurse Aide Registry.

On August 18, 2000, Ms. Holmes was employed at the Washington Nursing Facility. On that day, she was assisting a resident into bed. The resident became combative and began scratching Ms. Holmes. Ms. Holmes did not seek assistance in moving the resident into bed. Instead, she continued to struggle with the resident and eventually hit her in the head with her fist, causing a knot to form over the resident's eye. Ms. Holmes promptly reported the incident to her superiors and also signed a statement admitting that she struck the resident. Petitioner's Ex. 119.

[5] For the same reason, I will not resolve the dispute between the parties about whether Ms. Holmes left the bathroom door open when she returned to Resident A's room. Resolution of that dispute has no bearing on whether Ms. Holmes neglected the resident by leaving her unattended in the tub.

III. Conclusions of Law

Pursuant to 29 DCMR 3252.7(d), a nurse aide must be listed in the Abuse Section of the Nurse Aide Registry if he or she "knowingly abused or neglected a resident." The regulations define "abuse" as "the infliction of physical or mental harm on a nursing home resident," and "neglect" as a failure "to carry out or perform, or to be remiss in the care for or treatment of[,] a nursing home resident." 29 DCMR 3299.1.

The regulations require that the Government's proposed listing of a nurse aide in the Abuse Section of the Nurse Aide Registry must be upheld "unless the nurse aide requests a hearing and disproves the charges against him or her." 29 DCMR 3252.7(d). Shifting the burden of proof to the nurse aide, however, violates the Administrative Procedure Act, D.C. Code § 1-1509(b). That section requires that "the proponent of a rule or order shall have the burden of proof."[6] In this case, the Government is the "proponent" of listing Ms. Holmes in the Abuse Section of the Registry. Accordingly, I ruled at the outset of the hearing that the Government bears the burden of proof and I reaffirm that ruling now.

[6] Section 1509(b) allows the burden of proof to shift from the proponent of the rule or order "as may otherwise be provided by law." Because no statute authorizes the regulation's attempt to shift the burden of proof, the "otherwise . . . provided by law" language is not applicable.

The evidence relating to the January 10 incident is sufficient to satisfy the Government's burden of proof. By leaving a dependent elderly resident alone in a bathtub with the water running in violation of the facility's express instructions, Ms. Holmes was "remiss in the care for or treatment of a nursing home resident" and her actions therefore constitute neglect within the meaning of 29 DCMR 3299.1.[7]

Ms. Holmes' primary contention at the hearing was that she should not be listed in the Abuse Section because she did not abuse Resident A. She believed that including her name on the list would be a finding that she had killed Resident A or intentionally harmed her. She insisted that she did not intentionally abuse Resident A, but readily admitted that she neglected her. The Government agrees that the evidence does not establish that Ms. Holmes abused Resident A; instead, its theory, which is established by a preponderance of the evidence, is that Ms. Holmes neglected Resident A. Ms. Holmes, however, insists that her neglect of Resident A is an insufficient reason for including her in the Abuse Section of the Registry.

To be sure, the term "Abuse Section" is not an accurate description of the listing required by the regulation, as those who have abused residents *and* those who have neglected residents are

[7] As noted above, the regulations require the listing of any nurse aide who "knowingly abused or neglected a resident." 29 DCMR 3252.7(d). It is unclear whether "knowingly" modifies both "abused" and "neglected", thereby requiring the Government to prove that Ms. Holmes knowingly neglected Resident A. In this case, Ms. Holmes' testimony that she was aware of the instruction not to leave a resident alone in the tub establishes that her neglect was knowing. I need not decide, therefore, whether an aide who neglects a resident, but does not do so knowingly, should be listed in the Abuse Section of the Nurse Aide Registry.

included on the list. 29 DCMR 3252.7(d). Nevertheless, the purpose of this proceeding is not to prescribe a better name for the list. My only function is to decide whether the Government has proved that Ms. Holmes' actions on January 10, 2000 meet the requirements for placement of her name on the list, regardless of what that list is called. As described above, the Government has met that burden.

Because the Government's burden is to prove that Ms. Holmes neglected Resident A, the dispute between the parties concerning the cause of Resident A's death is immaterial. The definition of "neglect" focuses upon the aide's actions, not the results of those actions. By leaving Resident A alone in the tub for a substantial period of time, Ms. Holmes neglected her. Whether that neglect caused her death makes no difference.

The evidence concerning the August 18 incident is even clearer.[8] There is no dispute about the underlying facts. Ms. Holmes admitted that she knowingly struck the resident with whom she was struggling, causing a knot to form on the resident's forehead. This was the knowing "infliction of physical or mental harm on a nursing home resident," thereby satisfying the definition of "abuse" in 29 DCMR 3299.1.

[8] As noted above, Ms. Holmes consented on the record to an amendment of the August 10 notice letter to include the Government's allegation that she struck a resident of the Washington Nursing Facility on August 18, and agreed that evidence of the August 18 incident could be considered as a separate ground for listing her in the Abuse Section.

IV. Order

Based upon my findings of fact and conclusions of law, it is, this _____ day of _____, 2000:

ORDERED, that the decision of the Department of Health to list Respondent Keisha Holmes in the Abuse Section of the Nurse Aide Registry is **AFFIRMED**; and it is further

ORDERED, that, pursuant to 29 DCMR 3252.11, the Department of Health shall record Respondent's name in the Abuse Section of the Nurse Aide Registry along with the documentation required by that section. The documentation shall clearly state that this administrative court made no findings about the cause of Resident A's death; and it is further

ORDERED, that, pursuant to 29 DCMR 3252.12, the Department of Health shall circulate a copy of this Order to all nursing home administrators in the District of Columbia; and it is further

ORDERED, that judicial review of this order may be obtained by filing a petition for review with the District of Columbia Court of Appeals in accordance with D.C. Code § 1-1510 and the rules of that Court.

FILED 10/11/00

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John P. Dean
Administrative Judge